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The two groups of children and adolescents seen for emergency psychiatric treatment were studied in an attempt to determine what constitutes an emergency in child psychiatry, whose anxiety initiates consultation, what the precipitating factors are and how they can be predicted, and to ascertain who is crucial to the management of these problems. The first group was composed of 100 families, seen in a large community psychiatric clinic. The second was composed of 50 families, seen in private psychiatric practices. An emergency in child psychiatry is defined as that situation in which the significant adults around the child can no longer help him master his anxiety or provide ego support and controls. Notable differences between groups were found in age and sex, social class, family intactness, and type of behavior considered grounds for consultation by the referring source. Treatment approaches are suggested which are based on early intervention, consideration of the child's susceptibility to separation from significant adults, and the mobilization of family and community resources. (BP)

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EMERGENCIES IN CHILD PSYCHIATRY:

A DEFINITION AND COMPARISON OF TWO GROUPS*

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Understanding those events in a child or adolescent's life which constitute a psychiatric emergency is as important as recognizing emergencies in general medical or psychiatric practice. In many ways the problem is more difficult because the child disguises his problems by behavior rather than by talking about them. The ability to decode the crisis demands looking broader and deeper than the immediate behavioral problem that led to the referral of the child. Although it would seem that this would be understood without restating, it is the authors' experience that most children sent to them as emergencies were referred for specific disturbing behavior despite long-standing manifestations of developmental problems. Most of the young people referred as emergencies

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*Presented at the 1967 annual meeting of the American Orthopsychiatric Association.

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showed urgent behavioral symptoms, often in response to well defined crises in their lives, yet most were poorly prepared for the stresses of normal development. The authors will attempt to describe a number of factors which led to the crisis in the child's life and to further clarify those events that precipitated referral as an emergency of child psychiatry. We would like to determine what constitutes an emergency in child psychiatry, to define whose anxiety initiates the consultation, to discover the precipitating factors and their predictability and to ascertain who is crucial to the management of these problems.

Clinical Experience

Two groups of families who presented a child or adolescent as an emergency have been studied. One group, consisting of the first one hundred families seen as emergencies of child psychiatry in a large community psychiatric clinic*, was compared with the second group of fifty families who were seen in emergency consultation in the authors' private practices. All of the children and their families were seen during a period of two and one half years. All of the families were seen diagnostically within three days of their request for help, the majority the day of their request. Approximately half of the clinic group were first interviewed in the emergency room of a large university hospital** and then more comprehensive diagnosis and treatment took place in the outpatient clinic. The group from private practice were usually seen throughout the diagnostic and treatment period in the private child psychiatrists' offices. The groups were compared as to age, sex, social class (Hollingshead & Redlich),[13]

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sibling order, family intactness, the behavior precipitating the referral and the crisis in the family if known. The behavior precipitating emergency child psychiatry evaluation of the one hundred and fifty patients included suicide attempt and threat, acute school refusal and phobia, manifestations of hysterical conversion, acute anxiety and panic states, bizarre behavior including psychosis, threatened assault, sexual promiscuity, precocious pregnancy, fire setting, drug misuse and intoxication, abuse of pets, acute delinquent behavior, and incestuous relationship with a parent.

Definition of an Emergency in Child Psychiatry

Burks and Hoekstra[7] reported on a workshop about psychiatric emergencies in children at the 1961 Annual Meeting of the American Orthopsychiatric Association. The "participants considered children with suicide attempts, incipient psychosis and acute school refusal as bonafide emergency situations requiring prompt clinic intervention." Many referrals were felt to result from family crisis rather than from an intrapsychic crisis in the child. They stated, "the finding that referring sources erroneously viewed some dramatic misbehaviors as psychotic seems to indicate that the request for emergency evaluation be honored so that adequate diagnosis and proper treatment can be undertaken". Our own experience would support the view that many referral sources reacting to chronic environmental tolerance of the child's difficulties, overstated or dramatized the child's current behavior to stimulate rapid intervention.[19]

With the frequency of multiple problems in both groups studied, the authors often asked themselves, "What is different about this crisis?" We were unable to determine the seriousness of the emergency by telephone and we accepted the high anxiety of the parent or referring source as sufficient evidence for immediate consultation. The often-surprising tolerance of difficulties that we

considered of a serious nature, made us question whose anxiety initiated the referral. We have attempted to understand this problem by exploring the reasons for the emergency consultation with the referring physician, school or community agency with the conclusion that different or varied criteria have been used by each referral source to determine the point for emergency referral.

The authors have focused on the normal emotional dependence of the child in defining an emergency with their conviction that the emotional disturbance in the family incites crisis and leads to distortions or blocks in the emotional growth of the child. We have defined an emergency in child psychiatry as that situation in which the significant adults around the child can no longer help him master his anxiety and can no longer provide temporary ego support and controls. Parental absence, anxiety or helplessness in the face of environmental events provoke a situation which is experienced by the child as desertion and isolation. The child's coping manuevers include withdrawal (suicide attempt, school phobia, conversion, dissociation); projection (assaultive and delinquent behavior); or decompensation (panic and psychosis).

Comparison of the Groups Under Study

Comparison of the two groups, one from a large community psychiatric clinic and the other from the private practice of child psychiatry, showed both predictable and unexpected similarities. Differences too, were found that deserve further study.

Although in general the age distribution was similar (Table I), there was a divergence noted in the small number of girls fourteen and under seen in private practice. The clinic group seeks medical care primarily from the pediatric clinic and the emergency room of the general hospital; both of these resources serve as direct avenues of referral to the clinic. It may be that the

behavior problems of young children, especially girls, from higher socio-economic groups would be treated ordinarily by the general physician or pediatrician often without referral to a child psychiatrist. Three girls were seen for every two boys in the clinic population while almost the reverse was seen in the private practice group. The greatest proportion of girls in the clinic group was between the ages of twelve and eighteen, many of whom were referred for suicide attempt or threat. Adolescent girls seen in private consultation presented a broad distribution of symptoms, precipitating emergency referral. The majority of adolescent boys referred privately showed assaultive and delinquent behavior, but there were few in that category in the clinic referrals. Boys eight and younger were the only age group with a predominance of assaultive and destructive behavior in the clinic. Fire setting, killing of pets and assaultive behavior led to referral for psychiatric consultation. In contrast to our experience in private practice, boys were referred to the clinic more frequently than girls only while they were under nine years of age.

Social class distribution (Table II), using the Hollingshead and Redlich Classification [13] revealed as would be predicted that the private practice group was predominantely from Class III of the population, with almost equal numbers from Classes II and IV; the mean of the clinic population was a full social class lower, that is Class IV. In the clinic group a large number of families were from Class V with only one of ten families from Class III and none were from the higher social class levels of the population.[4,5]

Family intactness (Table III) was also notably different with only fifty-two percent of families in the clinic group intact as compared to 90% of families in the private group. Intactness was defined as the presence of two parent figures including step parents or foster parents and did not take into account such

important but difficult to assess issues as emotional isolation or withdrawal of parents. It was noted that the mother was present in all of the private practice families in contrast to seven percent of the clinic families with only the father as the remaining parent.

We have explored the implications of the social class distribution and family intactness by reviewing certain types of behavior (Table IV) leading to referral of children in the different groups. In the prelatency and latency age boys, overt assaultive behavior was more frequently presented as an emergency symptom by parents from lower socio-economic groups. This may reflect the more disorganized living situation, a lesser degree of family intactness, differences in social and cultural values, differing means of channelling aggressive impulses between the two groups and a greater demand for the control and inhibition of aggressive impulses in young middle class children.[13] In comparing groups of adolescent boys there was a notable persistence of overt aggressive behavior in boys referred for private evaluation and treatment. Additionally, behavioral symptoms suggestive of sexual perversion were more frequent in the private group. Social and cultural values of parental and authority figures appears to predetermine different management for boys from the two groups compared for sexual and aggressive behavior that constitutes some threat to the community. Speculatively, adolescent boys with offensive sexual or aggressive behavior from lower socio-economic groups would more routinely be sent to a juvenile court setting. Aggressive behavior directed toward parents by children from this group is usually intolerable and elicits retaliation, direct suppression or ejection from the home. On the other hand, boys of middle or upper middle socio-economic groups with delinquent, sexual or aggressive behavior are more likely to be referred for psychiatric evaluation and treatment although several of these adolescents had been seen and referred by the juvenile court. There

were few referrals for school phobia or school refusal in the adolescent boys from the clinic with several referrals for this problem in the private group. Group attitudes toward educational achievement (i.e. completion of high school and college attendance) may influence the higher frequency of referrals for this difficulty in the private group. It is feasible that the adolescent boy, from lower socio-economic groups who may be causing some behavioral disruption, is passively allowed to quit school without pressure either from his family or the community. There is little likelihood of a boy from a middle class background being allowed to quit school or to refuse attendance without eliciting considerable environmental response.

The groups were similar when compared for sibling order (Table V) with almost half of both groups being the first born in their family. In contrast, about thirty percent of the general population is first born.* We then determined how many of the children seen in emergency consultation were either the oldest or only child remaining at home after older siblings left for work, college or marriage. More than seventy percent of the children from each group studied were either the oldest sibling or only child at home.

For the purposes of this study the authors attempted to determine the specific symptom that led the family, the physician or social agency to refer the child for emergency psychiatric evaluation. However, none of these children presented single symptoms in isolation. In adolescent girls from the clinic there was a frequent combination of the symptoms of suicide attempt or threat, school refusal, sexual promiscuity and runaway. Not only did many of the young

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*Vital Statistics of the United States. 1900-1964. Vol. I. Natality, U.S. Department of Health, Education and Welfare.

people in their groups come to emergency psychiatric evaluation with a combination of symptoms, their past histories revealed previous crises, often with completely different symptom complexes.[28]

Our experience in emergency consultations indicated that the immediate crisis in the family was precipitated by threatened separation, actual object loss or the anniversary of such a loss. This finding generally agrees with the work of several authors who have related separation experiences to the precipitation of crises.[8,12,15,16,21,23] Four out of five of the children in each group (Table VI) were in that category. More than sixty percent of the children seen in emergency consultation had lost a parent or near relative through illness, hospitalization, marital separation or death within three weeks of the onset of their symptoms. In addition impending high school graduation or return to school, a family move to a new neighborhood or city, break up with a girl friend or boy friend or hospitalization of the patient also represented significant threats of separation.

Discussion

In reviewing experiences with children and their families referred on an emergency basis, a wealth of thought provoking questions arose. Theoretical work by Caplan[8], Erikson[11] and Hill[12] has laid a foundation for clinical study and testing but much of the practical application of this work has yet to be performed and evaluated. Comprehensive study of individual symptoms such as school refusal and phobia[9,10,18], hysterical conversions[22], suicide attempt and threat[17,26,27,29] runaway[24], assaultive behavior[6], and delinquency[14] are derived from usual clinical practices. Emergency psychiatry services for children[25], which are confronted urgently by all of these symptoms, are just beginning to develop practical means for synthesizing the constructs of crisis theory, family interactions

and individual dynamics. To date the reports concerning the evaluation and management of psychiatric emergencies in children and adolescents appears to come largely from community clinics which treat patients primarily from socio-economic groups of Class IV and V. Additionally, these reports categorized only three situations as emergencies. Acute psychotic decompensation, suicidal expression, and acute school phobia are generally agreed upon as conditions demanding quick intervention. Both psychotic decompensation and suicidal expression, because of the potential aggressive action either to the self or others, fall within the scope of all conditions defined as medical emergencies, i.e. those which constitute a threat to biological integrity or life. The recognition or acceptance of acute school phobia as an emergency situation warrants consideration for a different definition of an emergency in child psychiatry. Traditionally, child psychiatry addresses its concern to the growth and development of the child by integrating understanding of both physical and emotional growth, by recognizing and dealing with those factors which interfere with emotional maturation and by centering its concerns upon ego development in all of its ramifications. Psychoanalysis focuses on the ego as a source of psychological adaptation with the utilization of the defense mechanisms to this end. The still growing field of ego psychology examines not only mental mechanisms and behavior patterns but also explores possible biologic anlagen of these mechanisms. It attempts additionally to understand the position and influence of cognition, motility, sensory perception and alterations of biologic function as they affect ego strength and development. Since refusal to attend school does not constitute a serious physical threat to the child we must assume that concern is reflected about his missing an experience which contributes in a number of dimensions to ego development at that given point in his life.

One must examine the position of significant adults in a child's life to

foster and maintain consistent ego development which permits appropriate gratification of impulses, provides flexible adaptation to stress, and develops defenses which aid in conflict resolution without impairing growth. Particularly we are concerned with the role of adults for ego lending and ego support during periods of emotional crisis for the child. Recognizing that the natural emotional dependence of children upon adults, we can anticipate the effect of an anxious disorganized adult upon an anxious dependent child who may be looking to him for support, security and modes of conflict resolution. One may then hypothesize that those situations in which a significant adult is unable to foster ego growth, to provide ego controls and to indicate avenues of tension reduction potentially constitutes a serious impairment to ego development of the child.

Caplan, Lindeman and others have indicated that successful crisis resolution provides a small but significant emotional development for the individual, potentially enhancing his capacity for meeting later stresses without necessarily effecting recognizable characterologic change. We find it essential to return to the theory of crisis intervention in defining what is a crisis or emergency in child psychiatry. Caplan[23] defines crisis as "an upset in a steady state" emphasizing that an individual strives to maintain a state of equilibrium through a constant series of manuevers. He further notes, "individual differences in coping resources and resilience within the child, as well as differences in support from the environment, help to determine which children can weather these stresses sufficiently to permit continued growth, and can develop increasing capacity to reach workable relationships with the envioronment."[8] Rubin Hill in his study of Families Under Stress defines crisis as "any sharp or decisive change for which old patterns are inadequate..... A crisis is a situation in which the usual behavior patterns are found to be unrewarding and new

ones are called for immediately."[12] Erikson[11] has stressed that the zones of development most seriously blocked or distorted by disintegrative reactions to extreme stress or crisis are apt to be those whose maturation is still incomplete or the most recently acquired functions and the zones dynamically related to them. During periods of relatively rapid ego development, unresolved crises distort this development and lead to regression, withdrawal, or the utilization of maladaptive defense mechanisms. Accordingly, we have chosen to broaden the definition of emergency in the practice of child psychiatry focusing not only on the degree or kind of disturbance in the child but also scrutinizing the degree of anxiety, helplessness, and disorganization existent in those adults who are most closely involved with the child in his immediate life situation.

Although our initial reaction was perhaps intuitive and empathic we have attempted to define more objectively the responses of the significant adults in later deciding which cases should be seen on an emergency basis. One family function discussed by Ackerman[1] is the capacity to encapsulate or contain significant psychopathology in one or more family members. We are utilizing the concept of the extended family to recognize the importance of the role of significant related, as well as non-related, individuals in total family functioning. Experience has lead us to include school counselors, family physicians and pediatricians, welfare workers, and others both in the evaluation of acute situations and in our planning for management and treatment. The chronicity of behavioral problems and neurotic symptoms in children presented as emergencies draws one to the question of which adult withdrew from an adaptive system which had been functioning efficiently up to the point of crisis in controlling or warding off unmanageable anxiety. An emergency in child psychiatry may then be defined as that situation in which the significant adults around the child can no longer help him master his anxiety and can no longer provide temporary ego

support and control; parental absence, anxiety, or helplessness in the face of environmental events provoke a situation experienced by the child as desertion and isolation during periods of high anxiety associated with normal developmental stress.

Treatment approaches, we believe, can be planned along lines based on the developmental model defined. To be effective, therapeutic intervention for these children must include the parents and other significant adults in their environment. Immediate diagnostic evaluation and treatment utilizes techniques of conjoint collaborative interviewing, brief psychotherapy [2,3,4] and family therapy. [1,20,21] With the goal of early psychiatric management of child and family crises we are focusing psychiatric attention toward prevention and early alleviation of emotional disorders. The important aspects of such an approach includes the initial appraisal of the child and his family as quickly as possible; the reestablishing or development of communication within the family and the environment by the emergency treatment method chosen, the establishment and maintenance of good working relationships with various community agencies, schools and clinics; and the provision of sufficient flexibility within the treatment program to afford the intensity of contact to achieve these purposes.

Summary

The authors have compared two groups of children and adolescents seen in child psychiatry emergency consultation to formulate a more dynamic definition of psychiatric emergencies in children. The two groups, one from a large psychiatric outpatient clinic and the other from the authors' private practices, provide a wide range for comparison of age, sex, social class, sibling order, family intactness, type of symptom or behavior precipitating the emergency referral and type of family crisis. The definition of an emergency in child

psychiatry is based on the relative ego development of the child with the realization that the child is still largely dependent on a number of adults in his environment. Treatment approaches are suggested which are based on early intervention, consideration of the child's susceptibility to separation from significant adults and the mobilization of family and community resources.

TABLE I

AGE AND SEX OF CHILD IN CRISIS

(In Percentages)

CHILD AGE GROUPS IN YEARS	TOTAL		BOYS		GIRLS	
	CLINIC N=100	PRIVATE N=50	CLINIC	PRIVATE	CLINIC	PRIVATE
4 - 8	17	8	10	4	7	4
9 - 11	10	12	5	10	5	2
12 - 14	31	30	12	26	19	4
15 - 17	42	50	13	26	29	24
TOTAL	100	100	40	66	60	34

TABLE II

FAMILY SOCIAL CLASS DISTRIBUTION*

(In Percentages)

CLASS	CLINIC N=100	PRIVATE N=50
II	--	26
III	11	50
IV	57	24
V	32	--
TOTAL	100	100

* Hollingshead and Redlich (1958).

TABLE III

FAMILY INTACTNESS

(In Percentages)

	CLINIC N=100	PRIVATE N=50
Intact*	52	90
Mother Only	38	10
Father Only	7	--
Institutionalized	3	--

* Family considered intact if a step-parent present

TABLE IV

CHILD'S SYMPTOM OR BEHAVIOR PRECIPITATING REFERRAL AS CHILD PSYCHIATRY EMERGENCY

(In Percentages)

SYMPTOM OR BEHAVIOR	CLINIC N=100	PRIVATE N=50
Suicide attempt or threat	34	12
School refusal (school phobia)	14 (7)	28 (12)
Assaultive behavior	5	22
Hysterical conversion (paralysis or seizures)	12	4
Acute anxiety (panic, night terrors)	9	6
Exhibitionism or Voyerism	3	8
Bizarre behavior (hallucinations, delusions, compulsions)	6	4
Delinquent behavior	2	6
Sexual promiscuity	2	2
Fire setting	4	--
Drug intoxication	3	--
Incest	3	--
Threatened school expulsion	--	6
Acute grief (parents death)	1	2
Killed pets	2	--
TOTAL	100	100

TABLE V

SIBLING POSITION OF CHILD IN CRISIS

(In Percentages)

ORDER	CLINIC N=100	PRIVATE N=50
First Born	53*	48t
Second	24	34
Third	12	16
Fourth or later	11	2
Only Child	4	10
Youngest Child	16	30
Four or More Children in Family	43	18

* An additional 18% were second born or later but oldest or only child at home during crisis.

t An additional 26% were second born or later but oldest or only child at home during crisis.

TABLE VI

CRISIS IN THE FAMILY - CONSULTATION OCCURRED

WITHIN THREE WEEKS OF EVENT

(In Percentages)

		CLINIC N=100		PRIVATE N=50
Separations - Object Loss:		61		62
Serious illness of parent	22		24	
Separation of parents (marital)	14		2	
Death of a parent*	7		4	
Separation from significant adult	7		16	
Family move with school change	5		6	
Break up with boy friend or girl friend	4		4	
Child's hospitalization (surgery or injury)	2		6	
Threatened Separations:		18		24
Impending high school graduation	3		2	
Return to school or college	3		2	
Return home from college	--		6	
Reactivated family triangle (adolescence)	9		2	
Menarche or puberty changes	3		12	
Chronic Family Problems (with no known change):		21		14
TOTAL		100		100

* Includes four anniversary reactions.

REFERENCES

1. Ackerman, N.W. 1958. Toward an integrative therapy of the family. American Journal of Psychiatry. 114: 727-733.

2. Avnet, Helen H. 1965. How effective is short-term therapy? In Short Term Psychotherapy. Louis R. Wolberg, ed. Grune and Stratton, New York. Pp. 7-22.

3. Bellak, L., and Leonard Small. 1965. Emergency Psychotherapy and Brief Psychotherapy. Grune and Stratton. New York.

4. Bernard, Viola, W. 1965. Some principals of dynamic psychiatry in relation to poverty. American Journal of Psychiatry. 122: 254-267.

5. Brill, N.Q., and H.A. Storrow. 1960. Social class and psychiatric treatment. Archives of General Psychiatry. 3: 254-267.

6. Burks, H.L., and Saul I. Harrison. 1962. Aggressive behavior as a means of avoiding depression. American Journal of Orthopsychiatry. 32: 416-422.

7. Burks, H.L., and M. Hoekstra. 1964. Psychiatric emergencies in children. American Journal of Orthopsychiatry. 34: 134-137.

8. Caplan, Gerald. 1961. Prevention of Mental Disorders in Children. Basic Books, Inc. New York.

9. Coolidge, J., Tessman, E., Waldfogel, J., and M. Witter. 1962. Patterns of aggression in school phobia. In the Psychoanalytic Study of the Child. Volume XVII. International Universities Press. New York. Pp. 319-333.

10. Eisenberg, L. 1958. School phobia: Diagnosis, genesis, and clinical management. Pediatric Clinics of North America. 5: 645-666.

11. Erikson, E.H. 1963. Childhood and Society: Second Edition. New York.

12. Hill, Rubin. 1949. Families Under Stress. Harper and Brothers. New York. p. 51.

13. Hollingshead, A.B. and F.C. Redlich. 1958. Social Class and Mental Illness. John Wiley and Sons, Inc. New York.

14. Kaufman, Irving, and Lora Heims. 1958. The body image of the juvenile delinquent. American Journal of Orthopsychiatry. 28: 146-159.

15. Levi, L.D., Fales, C.H., Stein, M., and V.H. Sharp. 1966. Separation and attempted suicide. Archives of General Psychiatry. 15: 158-164.

16. Lindeman, Erich. 1966. Symptomatology and management of acute grief. In Crisis Intervention: Selected Readings. Howard J. Parad, ed. Family Service Association. New York. Pp. 7-21.

17. Mintz, Ronald S. 1966. Some practical procedures in the management of suicidal persons. American Journal of Orthopsychiatry. 36: 896-903.

18. Malmquist, C.P. 1965. School phobia: A problem in family neurosis. Journal of the Academy of Child Psychiatry. 4: 293-319.

19. Morrison, G.C. 1966. Therapeutic intervention in a child psychiatry emergency service. Presented in abridged form at the annual meeting of the American Association of Psychiatric Clinics for Children, San Francisco.

20. Morrison, G.C. and J.C. Collier. 1967. Family treatment approaches to suicidal children and their families. Will be presented at the annual meeting of the American Association of Psychiatric Clinics for Children, Washington, D. C.

21. Parad, Howard J., and Gerald Caplan. 1965. A framework for studying families in crisis. In Crisis Intervention: Selected Readings. Howard J. Parad, ed. Family Service Association. New York. Pp. 53-72.

22. Proctor, James T. 1958. Hysteria in childhood. American Journal of Orthopsychiatry. 28: 394-407.

23. Rapoport, Lydia. 1965. The state of crisis: Some theoretical considerations. In Crisis Intervention: Selected Readings. Howard J. Parad, ed. Family Service Association. New York. Pp. 22-31.

24. Robey, A., Rosenwald, R.J., Snell, J.E., and Rita Lees. 1964. The runaway girl: A reaction to family stress. American Journal of Orthopsychiatry 34: 762-767.

25. Sargent, D.A. 1964. The children's emergency service. Acta Paedopsychiatrica (Basal). 31: 108-112.

26. Shaw, C.R., and R.F. Schelkun. 1965. Suicidal behavior in children. Psychiatry. 28: 157-168.

27. Shneidman, E.S., and N.L. Farberow. 1961. Statistical comparisons between attempted and committed suicides. In The Cry For Help. N.L. Farberow and E.S. Shneidman, eds. McGraw-Hill Book Company, Inc., New York. Pp. 19-47.

28. Smith, W.R. and G.C. Morrison. 1967. Emergencies in Child Psychiatry: Tolerance of long standing neurotic and deviant behavior preceeding the crisis. Will be presented at the annual meeting of the American Psychiatric Association.

29. Tuckman, J. and H.E. Cannon. 1962. Attempted suicide in adolescents. American Journal of Psychiatry. 119: 228-232.